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ABSTRACT

This report of a conference on state boards of nursing and education for nursing contains the following papers: "Relationship between State and Voluntary Accreditation," by Eloise R. Lewis; "Statewide Planning for Nursing Education," by Donald P. Draine; "Nursing Education Today and in the Future," by Irene S. Palmer; "The Professional Association's Responsibility for Nursing Education," by Hazle Blakeney; "The Role of State Boards of Nursing in Post-Basic Nursing Education," by Patricia A. Wagner; "The Development of Criteria for Accreditation and Curriculum Innovation," by Emily I. Gardner; "Examining Various Approaches to School Surveys and the Role of the State Board of Nursing Education," by Annie L. Lawrence; and a brief summary of group discussions. (SW)

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# Relationship Between State and Voluntary Accreditation

*By Eloise R. Lewis, Ed. D., R.N.*
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**Introduction**

I am glad to be here today to share in this timely conference where members of a profession concern themselves with the laws that regulate its practice and have a close relationship with the Boards which administer those laws. In addition, we should have equal concern with those accrediting agencies which are voluntary.

Perhaps it would be useful to suggest that my own perceptions and understandings are influenced by:

1. Twelve years as a member of the North Carolina Board of Nursing where I served as:
   Chairman, Education Committee
   Vice Chairman
   Chairman of the Board and in that capacity Chairman of the Executive Committee
2. Preparation for and participation as a member of accrediting teams for the Council of Baccalaureate and Higher Degree Programs.
3. Experience as an active member of the Southern Association of Colleges and Schools Accrediting Team.

In the pursuit of my professional career I have been on "both sides of the fence" and have had the privilege of seeing our accrediting services grow from rigid dictitorial, frightening experiences to a participatory, peer review exchange that encourages growth and movement toward improved standards for both education and practice.

For most of you the remarks which I have chosen to make will not be new but rather will be a review and a refocus on a critical national issue which demands the best thinking of the leaders of our time. Through the ages, wise men have discoursed about the *Hereafter*. Fewer have considered the *Heretofore*. A brief review of the Heretofore in accreditation, both state and voluntary, will enhance our understanding of the present and give direction for the future.

**Historical Base**

First, as you know, accreditation is peculiar to the United States. It developed in our country as a result of economic, social, and political factors which did not prevail in any other country. The historical growth and social traditions of the United States created many unique patterns of operation—accreditation is no exception. In other countries, Ministers of Education exert an influence in many ways comparable to that which have developed in accreditation as a means of maintaining standards in higher education.

The Constitution of the United States made no provision for a Minister of Education, and by adoption of the Tenth Amendment in 1791, authority for education was delegated to the states. The spirit of the times would not permit government to establish and maintain standards for post-secondary education. Institutions and professions were forced to regulate themselves. The result is the variety and multiplicity of agencies for voluntary accreditation.[1]

**Meaning of Accreditation**

Accreditation is a process which provides a service to the public—the protection of the public from inadequate educational institutions. It is a process by which an agency or an organization evaluates and recognizes an educational institution or program of study as meeting certain predetermined criteria or standards.

In his book on accreditation, Dr. William Selden made the following statement:

> Through an almost continuous barrage of criticisms accreditation has helped to bring about an elevation in the quality of education and a broad acceptance of a general concept of what constitutes a good college or university.[2]

**Types of Accreditation**

1. The first type of accreditation—general institutional—is concerned with the totality of the institution, with the interrelationships of its parts, and with the way in which the various parts comprise the total institution's pursuit of stated goals.
   General institutional accreditation means that no single segment is unacceptable.
   The latter part of the nineteenth century saw the development of what are now called general or regional accrediting agencies—"general" in that they are not concerned with specific fields of study, and "regional" in that they represent geographical areas of the United States.
   Institutions themselves encourage general accreditation which will stand: (1) in lieu of governmental approaches to the establishment of standards; (2) for their own protection; (3) for the maintenance of standards; and (4) for the admission of students from secondary schools to collegiate institutions.
   Though it is concerned with the component programs of an institution, institutional accreditation does not mean that each program in the institution is individually approved, or that it has been analyzed in depth by a professionally oriented group.
2. The second type of accreditation is that conducted in the various professional fields by organizations which are national in membership and scope and are concerned with specific fields of professional study. The professional accrediting services provide a stimulus to faculties to improve programs of study and provide a mark of distinction for those achieving the standards of excellence necessary to merit professional accreditation.
   Among the important points of commonality among the associations involved in voluntary accreditation is working with institutions to bring about improvement. Ideally this is done quietly and with a minimum of publicity.
   A major benefit to be derived from voluntary accreditation on the part of the institution is the self-analysis which precedes the submission of the report and the visit of the accreditation team.
3. The third type of accreditation is conducted through the state boards. Reasons for the development of this type of accreditation goes back to the

Jacksonian period in American history,which encouraged a laissez-faire attitude in many aspects of American life, specifically for our discussion, in education and admission to the professions. The states had the responsibility for establishing standards, but during the mid-1800's there was considerable relaxation in this responsibility, and admission to the professions was freer than it had been in the earlier days or at the present.

This factor, plus many other social, political and, economic developments, ultimately led to the increase in control and the situation as we know it today. It also led to freedom of operation within the professions and to identifying them with the responsibility of establishing their own respective standards, maintaining their own control, and—through boards of licensure—endowing their representatives with the authority to decide who enters the profession.

Co-existence of the three types of accreditation agencies can produce conflicts, overlapping, jurisdictional disputes, and feelings of support for one or the other. This situation is part of the uniqueness of the American system, but it often leads to confusion and may have prompted the Planning Committee to focus on the topic for this conference.

Since every person in the audience, I am sure, has had experience with all three types of accreditation, it seems appropriate to consider the overall functions of the process of accreditation.

As we proceed it might be useful for you to consider each of the functions in terms of the type of accreditation with which you are most familiar.

Many statements concerning the functions of accreditation appear in the literature. I will review with you the results of a study completed in 1973, by Dr. Jerry Miller of the American Council on Education, in which the primary functions, the secondary functions, and the desired by-products of accreditation are set forth: [1]

Primary Functions:

1. To identify for public purposes educational institutions and programs of study which meet established stndards of educational quality.
2. To stimulate improvement in educational standards and in educational institutions and programs of study by involving faculty and staff in required self-evaluation, research, and planning.

Secondary Functions:

1. To assist in the development of processes and instruments for evaluating institutions and programs of study and their educational achievements.
2. To provide assurance regarding curricular policy practices and requirements which enhance acceptance and cooperation and facilitate transfer of credit among a variety of types and levels of institutions.
3. To provide reasonable assurance that practitioners whose activities have a direct bearing on public health and safety or whose activities could cause irreparable harm to society meet minimum educational standards upon entry into the profession.
4. To identify for public purposes educational institutions and programs of study which adhere to accepted ethical standards in relationships with students.
5. To protect institutions and programs of study against external and internal interference by groups and individuals who seek to control, or distort, or divert the educational function to serve partisan interest or purpose.
6. To identify for public purposes educational institutions and programs of study which are making efficient use of their resources in meeting their stated goals and objectives.

Desirable By-Products:

1. To serve as a medium of communication for educational practices and ideas among institutions, individuals, and programs of study through widespread participation in the accreditation process.
2. To assist institutions and programs of study in obtaining resources needed to offer quality education by providing independent professional judgment.
3. To provide, on a comparative basis, information to the public about accredited institutions and programs of study.

Certain basic concepts in the primary and secondary functions, as well as in desired outcomes, are necessary and important to all three types of accreditation. Careful study of the types of accreditation suggest many commonalities.

In response to the question of which type of accreditation is more influential, let me say that voluntary accreditation is just as influential and fully as necessary for a viable educational institution as any requirement established by state law. Complementary to this is the realization that accreditation under state law can be accomplished in such a way as to provide for institutions a full measure of freedom and the incentive to initiative which educators so zealously proclaim as the *sine qua non* of the academic world.

**Differences in Voluntary and State Accreditation**

Review of the functions of accreditation suggest many similarities in the purpose of each group; what then are the differences?

When I think of the differences, I think, for the state, specifically of an accreditation requirement that finds its basis in the *law* as opposed to a voluntary system where evaluations are basically self-imposed and represent a peer method of externally monitoring all post-secondary endeavors.

In voluntary accreditation the general focus is that the strength of our educational system is derived, in large part, from the unique and diversified contributions of the individual institutions. The major contributions of the voluntary agencies are to:

1. Provide protection to society against ill-prepared technical and professional practitioners.
2. Aid licensing authorities and facilitate the transfer of students.
3. Help students and parents in identifying quality education.
4. Aid institutions in withstanding political and other non-educational pressures which are harmful to the institution or program of study.
5. Stimulate broad consideration of educational problems and issues.

To assist the voluntary agencies in accomplishing their mission they are themselves subject to the review process by the National Commission on Accrediting.

The tenet upon which any accrediting activity is based

is the importance of strengthening resources and improving the capacity of the institution to render a high degree of service.

The state accrediting agencies, by virtue of the licensing function, render a specific service to the public. They determine what kind of performance they expect of persons in a given occupation or profession, and then they set up the necessary means for determining whether or not those persons are capable of performing at the desired level.

In the long run, however, the public is going to be served in any particular field by those who serve it best. What the public has given us the exclusive right to do today, the public can take away from us tomorrow. The public that has given us the exclusive right to practice nursing can take it away or modify it at any time. It is well to remember that we are going to retain that exclusive right only so long as we serve the public better than anyone else.

When we think or talk about state accreditation, the general characteristic which seems to be emphasized is minimal standards—"minimum legal safety to practice." The point has been made that the legislature could not require average or superior standards, since the very basis for such a determination would force many many schools to close.

Herein lies the vulnerability of the state agencies. They are frequently subjected to political pressures, and in some cases the legislature passes bills that impede progress toward upgrading of standards.

It does not seem to me that a minimum needs to be absolute, except for a particular time. Most of you have heard the oft-quoted comment of H.L. Hazen that ". . . one never finds an institutional president with the point of view to ask, 'What is the passing grade, because I want my institution to get one percent above the passing grade.'"

It is generally accepted that specifics are easier to define and enforce in educational requirements and thus more easily and simply administered. I am convinced that the specifics must be minimized, both in the law and in evaluation, in favor of whatever subjects, methods, and schedules are best suited to the institution's own objectives.

Vivid illustrations of the meaning of the statements above can be readily recalled by nurse educators. In the past, legal curriculum requirements in many state laws required specifics such as one month in the Diet Kitchen and three months in the Operating Room, with 24 minor scrubs, 12 major scrubs, and 45 hours in O.R. Techniques. How much more flexible and educationally sound is the flexibility of present Nurse Practice Acts which require theoretical instruction and practical learning experiences for students in medical-surgical nursing.

Progress has been made, but the staff members of our Boards as well as all members of the profession must be constantly on the alert to prevent legislation which is not in the best interest of the consumer of health service or the practitioner.

The discussion of legal minimum requirements brings up an interesting point: the relationship of the licensing examination to the approval of the program. You could argue that if the basis for success in the licensing examination is related to the instruction and experience gained in a program of studies, and if the employment or service in one's field requires a license, then the program which does not adequately prepare its students for successful performance on the examinations is not meeting one of its fundamental reponsibilities.

Let me hasten to say that no academic institution would deliberately gear its program to the passing of an examination. One would find little argument against the thought that a program which is geared to successful achievement of its graduates on one SBTE is a poor educational program.

Despite the preceding statements, if one of the requirements for practice of a profession is a license, how does the accrediting agency—state or voluntary—justify the continued accreditation of a program where a high percentage of the graduates each year fail to achieve the license? What about obligations to students? Can we justify that the best interest of the public is being served? These are the questions that must be asked; what of the answers?

When a situation such as the one just described occurs, is it appropriate for the two agencies to communicate?

What happens when a nationally accredited program is found in non-compliance with the law by the state body?

As we strengthen lines of communication, is it reasonable to expect that such issues could be explored and solutions to the problems found?

**Areas of Confusion**

Earlier in the paper, the suggestion was made that there are areas in which confusion exists. Let us explore a simple one, confusion in the use of the words "accredit" and "approve." The voluntary agencies use the term "accredit"; some of the state boards use the term "approve," some "accredit."

The national publication listing all Schools of Nursing meeting minimum requirements set by law and board rules in the various jurisdictions is entitled *State-Approved Schools of Nursing—R.N.*

According to Webster, "accredit" means "To certify as a standard." According to Webster, "approve" means, "To confirm or sanction officially."

In March 1969, the National Commission on Accreditation developed a formal policy regarding legal agencies.

> As a result of federal legislation and other social pressures, accreditation of specialized or professional programs of study in colleges and universities has been increasing in importance. Although in our form of government the several states may exercise the legal authority to approve specialized and professional programs of study, and some presently perform this function by approving, recognizing, or registering institutions, it is the considered judgment of the National Commission on Accrediting that agencies of the states should not be listed as nationally recognized, specialized or professional accrediting agencies. Furthermore, the Commission holds that the term "accreditation" should be used exclusively by regional and national organizations and that state agencies should confine their activities to approving," "registering" or "recognizing" institutions or programs.
>
> Accreditation, as a form of guidance for and control of higher education in the United States, has developed primarily as a non-governmental function. It is companion to, but distinct from, the

government functions of licensure or certification of individuals. These two functions—accreditation of institutions or their programs of study and licensure of individuals—provide a balance to each other in which non-governmental agencies assume their respective and complementary functions. If government in the United States were to dominate both of these functions, the effective balance among government, education, and the professions, which has been developed during the present century, would be undermined and destroyed.

On the immediately practical level the recognition of state bodies for the accreditation of professional programs of study would lead to the real possibility of fifty or more agencies in each profession in which there is accreditation applying differing standards to the specialized and professional programs of study offered by colleges and universities. The consequences of such an eventuality are palpably undesirable and have, in fact, been a stimulus for creation of national accrediting agencies.

For these reasons the National Commission on Accrediting endorses the policy that state agencies should not be included on lists of nationally recognized accrediting agencies for specialized or professional programs of study.[4]

The National Commission posits its stand on the belief that accreditation for national consumption should be a non-governmental function in order to maintain an effective balance between licensure and accreditation.

The Commission's support for state approval as opposed to accreditation recognizes the necessity to comply with state requirements for certification or licensure, where it can be a stepping stone for institutions for national accreditation and where it provides a meaning for recognition of programs not eligible for accreditation by regional or national agencies.

State approval, while it can supplement or complement, cannot substitute for regional or national accreditation. State accreditation is incapable of providing the protection necessary for institutional freedom against harmful government or political pressures.

Perhaps this is the point at which we ask ourselves, "Are we properly structured to fulfill our social obligations of service to the public?"

Are the relationships of the state and voluntary accrediting agencies constructive, cooperative, and continuous? If not, why not?

Are there problems which need to be confronted squarely and worked on with vigor? It seems to me as an active participant in many phases of accrediting activities that there are five areas in which both voluntary and state accrediting agencies must work. They are:

1. Communication that looks toward improving understanding. Even persons that work in accrediting or approval agencies need to keep abreast of what is going on and what their colleagues in other agencies are doing.
2. Communication among those involved in accreditation, or approval, in education, and the general public. This is no easy task and demands the participation of all groups.
3. Keeping accrediting or approval policies and procedures relevant to rapidly shifting demands. Accrediting or approval agencies, like other social institutions, face the danger of serious social lag.
4. Providing leadership but not authoritarian direction.
5. Providing coordination of effect among accrediting and approval agencies. Not much of this has been done to date. It is fair to suggest that much more work in this area needs to be done.

**Conclusion**

Addressing a similar conference some years ago, Helen Nahm said, "In the years to come, I think it is urgent that cooperative efforts of voluntary and legal accrediting groups be continued. Through such efforts emerging problems relating to nursing education can be predicted and intelligent solutions to these problems can be sought.

"I believe the welfare of patients, students and of the nursing profession is at stake."[5]

It seems to me that her message is just as true as it was when spoken. Perhaps even more so—1974 has brought the beginning ferment over the appropriate agency for professional accreditation. Resolution of the problem will demand our best. Strengthening relationship between the various agencies can be the first step.

**References**


1. Ozimek, Dorothy. *Accreditation of Baccalaureate and Masters Degree Programs in Nursing, A Comprehensive Review*. New York: The National League for Nursing, 1974.
2. Selden, William K. *Accreditation: A Struggle Over Standards in Education*. New York: Harper and Brothers, 1960.
3. Miller, Jerry. *Organizational Structure of Nongovernmental Post-Secondary Accreditation*. Washington, D.C.: National Commission on Accrediting, 1973.
4. *National Commission on Accrediting/1949-69*. Annual Report of the Executive Director. Washington, D.C.: The Commission, 1969, 1-2.
5. Nahm, Helen. "Voluntary Accreditation of Nursing Programs/Its Past, Present and Future." *Accreditation/Professional Concern for the Public Interest*. Proceedings, Annual Conference for State Boards of Nursing. Kansas City, Missouri: American Nurses' Association, 1969, 25.

# Statewide Planning for Nursing Education

*By Donald P. Draine, Ph.D.*
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*Minnesota Higher Education Coordinating Commission*

Ours is a society of corporations.

Each one organizes under a constitution with a board or trustees for policy and legislation, with an executive for administration or implementation, and sometimes with a judiciary for evaluation. Each one organizes when persons who share concerns and goals lock arms to achieve these in concent.

Once duly authorized, each corporation becomes a legal person with rights, responsibilities, and treatment under law parallel to those of a physical being and individuated from other corporations as well as from other persons, even from its own members. In the United States, the Congress authorizes incorporation of states, leaving them autonomous in certain areas, such as education.

The 50 states themselves exclusively authorize corporations within the respective boundaries: public and private, religious and secular, educational, eleemosynary and commercial, and non-profit and for profit. The state legislatures ordinarily delegate authority to incorporate to a state agency. The legislatures also establish corporation-like boards and commissions, delegated to perform legislative responsibilities, such as operating state colleges, assuring quality in health manpower and educational programs, or creating coordination among agencies and corporations.

What results, then, is a corporate landscape literally crowded with pyramids, large and small, tall and short. Each legal operating unit has an independent board of control at its tip. Indeed, there are some agencies, like Boards of Nursing, that are tips with no underlying pyramids.

Throughout each corporation there might be an intercom of communication and coordination. This coordination is addressed at length in the standard manuals on organization and administration.

Coordination *between* corporations represents a totally unique problem. It is in the nature of governing boards to be sovereign, isolated; they do not communicate. You cannot get from tip to tip between corporate pyramids—from the Board of Nursing, say, to the Board of Medical Examiners to the Board of Health, to the University Regents, to the county and hospital commissions, to private institutional trustees, and perhaps within the pyramids to the Schools of Medicine, the Divisions of Health Sciences, the Colleges of Pharmacy and Public Health. These are instances relevant to health education and health occupations, but the catalogue depicts the complete scope of education and practice.

To correct this situation, legislators and government planners, often out of desperation, grasp at the all-too-obvious straw: build a bigger pyramid, a superstructure above boards controlled by a superboard. The hope seems to be that coordination within the superstructures will occur, based on a regulatory intercom throughout an increasingly complex pyramid. Thus we see designs for commissions on health, on human services, on personnel, on education, on rehabilitation, on resources, and so on.

Several states have already experienced the futility of added layers of bureaucracy, of rule from the top without assured acceptance at working levels, of coping with complexity which requires increased administration, paperwork, and uniformity. Above all, this approach simply expands the distance between the tips of these enlarged pyramids, stimulating a temptation to build even more massive ones.

In some cases, structures are desiggned so their tips reach up to pierce the legislative stratosphere itself, either through inclusion of elected officials on boards or through a clouding of the distinctions between operation and legislation. This design can negate the original reasons for delegation and impose undue burdens on busy legislators.

Another substitute for inter-board coordination has been the creation of advisory boards. These are shotgun marriages of persons with related or conflicting interests. Any resultant coordination is based on the assumption that representation is a value—which is true, particularly when boards have been exclusive—and that the nature of this value is to produce good operating behaviors—which is false, particularly when conclusions are based on majority rule and compromise.

At the very best, advisory bodies supercede or supplant corporate boards. At the worst, they produce regulation without established channels into these delegated boards for ratification.

In a society of pyramids, therefore, the coordinator is not king, but servant. What is needed is a process of communication and coordination between the tips of the pyramids. If coordination *of* is the intercom within a single structure, then coordination *between* comes from the construction of a communication network among many structures.

At the highest state level, the network carries data, information, and policy proposals. The network is the vehicle for carrying shared data and expertise in such a way that several boards simultaneously ratify policy for action. At sub-state levels, the network serves to convene working planners between pyramids in development: of relevant data, of shared programming, of coordinated resource allocation, and above all of policy recommendations for adoption by boards at the top.

Around a related issue, each board acts on a policy as it affects its sphere of influence; for instance, the schools of nursing in production of educated nursepower, the board of health in distribution and utilization of educated nursepower.

The Minnesota Higher Education Coordinating Commission is not a superboard. It is not even a pyramid. It is instead the telephone and cable company. Protocols between agencies recognize the Higher Edducation Coordinating Commission's (HECC) mandate to review and make recommendations about coordination of new and existing educational programs in all post-secondary institutions.

In Minnesota, an interagency agreement places overall health planning direction in the Comprehensive Health

Planning division of the State Planning Agency, makes it responsible for provision of health manpower information, and constitutes it as contact point for communication of agency manpower recommendations.

By the same token, the collection, storage, and dissemination of health manpower and facilities information resides in the State Department of Health. The purview of the Board of Health includes the state's health delivery systems and manpower utilization, particularly through the Division of Health Manpower's coordination of credentialing and of licensing boards.

It is agreed that the Board of Nursing is responsible in the areas of licensing, credentialing, accreditation of nursing programs, and coordination of clinical sites. Credentialing mediates between the production and utilization of nursepower. With the other licensing boards, the Board of Nursing is housed in the Department of Health for a coordinated provision of administrative services.

The manpower functions of the various boards, health and otherwise, cannot be performed without attending to strictly educational issues such as projected program enrollments, current and projected program outputs, the number and location of educational programs, and competency-fits between learning outcomes and job tasks. Hence, the boards maintain cooperative relationships with HECC. Conversely, HECC cannot attend to the strictly educational issues without other boards' concerns about supply/demand, credentialing, distribution, and utilization of educated manpower, and without inserting into curriculum design the valid considerations of user needs, indeed predictions of alternative future delivery systems.

Inter-board coordination is thus inevitable. It is a partnership in development, both of programs and of state policy.

Eleven members, appointed by the Governor with Senate approval, constitute the Minnesota Higher Education Coordinating Commission. Under the Executive Director, the staff has five divisions, including academic planning. These divisions reflect the various statutory mandates of the Commission: student financial aids, budget review, administrative agent for certain federal programs, and academic program review.

Very generally, Minnesota law charges the Commission with study and long-range planning for post-secondary education so that citizens are provided with a coordinated array of educational opportunities consistent with individual and social needs and with a rational allocation of available resources.

Part of the Commission statute requests all agencies and post-secondary institutions to cooperate with HECC in collecting data and in pursuing its charges. Thus, rather than being a board of control or a department of higher education, the Commission has only persuasive power based on *voluntary coordination*. Its strength, therefore, lies in the quality of its recommendations, in its success in soliciting the cooperation of pertinent constituencies, and in the scope of its mandate.

The program review portion of the Commission statute [136A.04 (d)] best reflects this scope:

- "new and existing educational programs": it is not confined to new programs alone, or to programs at one level such as graduate programs; it includes ratification of new and present programs, increases, decreases, and discontinuations;
- "plans, proposals and priorities": it includes review of planning and developmental functions as well as the relative benefits of completed proposals;
- "the University, state colleges, state community colleges, public area vocational-technical institutes, and private collegiate and non-collegiate institutions": along with state agencies, it is not limited in any way but includes even proprietary schools, hospitals and the like;
- "review and make recommendations": it is not regulatory but persuasive in force; because unspecified, its audiences are the executive and legislative branches as well as the post-secondary institutions themselves; thus its recommendations potentially affect certification of adequate coordination, of competent planning and therefore of safe decisions about resource allocation; and of statewide policy when endorsed at the highest level of state government.

The Commission set the foundation for the force of "review and recommend" in 1969 when it defined the criteria for review of educational programs. There were three criteria, but among the data required for proposals lay a fourth: (1) need; (2) mission of institution or system; (3) unwarranted duplication; and (4) cost-benefit.

During four years reviews and evaluations have resulted in formal Commission action on over 800 programs, eleven new institutions, and 250 informational documents. The staff maintains a current inventory of all post-secondary programs. Structures and processes have been tested for review and policy development related to existing programs by application of planning models to nursing education, human services education, agriculture education, non-traditional studies, and health education.

The statewide advisory structure, in addition to staff evaluations, includes system representation on a Curriculum Advisory Committee and development of premiere advisory committees by broad discipline. Current efforts aim at establishment of a network of local/regional advisory structures by program and by geographic area.

The basic decision-making model unites data and expertise in a process accepted as having integrity. The data model produces information about projected student pool by program, about present and projected output capacity by program for the state and for regions, and about present and projected manpower demand statewide and regionally. The expertise model, with organization design assistance from staff, convenes both producers and users of educated manpower to assess the data relative to quantitative need and program content relative to qualitative need. The network model unites planners at the working level regionally and across regions for program design, development, and evaluation, and produces communication upward to area and state levels for review and ratification of policy recommendations. Current efforts to increase inter-agency cooperation will permit simultaneous ratification of policy recommendtions by parent boards responsible for production and utilization of educated manpower.

Thus statewide planning in Minnesota avoids production of master plans, whether for institutions or for disciplines such as nursing. Instead it emphasizes a plan-

ning process that is reiterable, that employs types of data required for curriculum and resource decisions, that produces state policies which certify resource decisions and which guide faculty planners in adapting to needed program changes in production and competencies, that involves both producers and users of educated manpower, and that binds participants in an information/recommendation network from the local level to the top policy boards in the state.

Actually statewide planning for nursing education was HECC's earliest and most successful application of the Minnesota planning process design—a credit to nursing and nursing education.

A delegation of nurses, including representatives from the State Board of Nursing, approached HECC voluntarily in 1972 to request coordination services. We believe the same spirit exists among nurses in every state.

With the help of nurses we proposed the design of the Advisory Committee on Nursing Education (ACNE) representative of every facet of nursing education, nursing practice, and users of nursepower, plus consultant members from the Board, from professional organizations, and from health-related state agencies.

The Northlands Regional Medical Program, Inc., provided a $10,000 grant which allowed the Commission to acquire additional help for ten months to staff this coordination effort and conduct studies according to our data model.

The objectives were modest, but they proved effective. Staff provided data, much of it from existing records in the Board of Nursing. ACNE provided expertise.

The study predicted entering enrollment patterns for R.N. and P.N. programs statewide to 1980, using an econometric formula validated against actual enrollment patterns experienced since 1952. By the same token, these entering enrollment patterns were driven through programs to graduation, licensure, and work force participation.

Prior HECC inventories, studies conducted in cooperation with CHP and Interstudy (Institute for Interdisciplinary Studies) provided information on R.N. and P.N. programs by institution, location, level, and annual output capacity. Program review and other sources of information revealed plans for additional and decelerating programs.

By an econometric model, the total stock and labor force participation rates for R.N.s and L.P.N.s were projected to 1980 and validated through use of extant data going back to 1952. These data permitted prediction of nursepower demand statewide and within health planning regions and accounted to a known extent for in- and out-migration.

ACNE supplied expert reinforcement of all the data, plus estimates in specific areas, such as private duty nursing. Most of all, ACNE provided the expertise of the profession across the broad range of nursing education and practice. It formulated realistic objectives for this overture into statewide planning. It certified acceptance of the study model. It monitored data and the study en route and evaluated its findings. It collaborated with staff in devising conclusions and in formulating the policy statements mentioned below. It assisted in proposing these policies to HECC, a Commission at the highest level of state government. It designed the next steps for further pursuit of statewide planning.

We like to think it communicated with the represented boards and other nursing constituencies throughout each phase, but particularly in advance of policy adoption by the Commission. Thus the Commission had advance assurance of ultimate acceptance through pre-negotiations at the non-ambassadorial level. Indeed the entire effort received adequate publicity through meetings and publications of the Nursing Board and state and regional associations.

After adoption by HECC, the policies were endorsed by the Board of Nursing and were used several times in decision-making.

The widespread acquaintance with these policies caused them to be employed as guidelines in the planning of additional or decelerated programs. Moreover, the policies indirectly stimulated design of several consortium and career ladder developments.

The Curriculum Advisory Committee and, consequently, the Commission referred to these policy guidelines in review of proposals to add or drop programs and in certifying availability of clinical sites for innovtive programs.

Finally, several legislative committees on health became acquainted with ACNE and the Report. Legislators expressed satisfaction and encouraged HECC to provide comparable information for other disciplines.

In June, 1973, the Commission adopted Planning Report 12, *Planning for Nursing Education in Minnesota*, with its policy recommendations. The Report has been available in draft. We expect to publish it in edited form.

In summary form, the policies included:

*Guidelines*

Guidelines for statewide planning for nursing education were recommended by the Advisory Committee. The guidelines fall into two groups: specific recommendations for the coming year regarding the number of program admissions and the location of new programs, and general recommendations regarding the ongoing planning process.

*Specific Recommendations*

1. The total number of entry positions to L.P.N. and R.N. programs in 1972 shall be maintained for the coming year, with annual review for subsequent years. The 1972 total is understood to include new programs that have already been reviewed favorably by the Curriculum Advisory Committee but have not yet been implemented. This does not prevent a shift in the proportion of new entering nursing students in each type of degree program within the R.N. category; it only controls the statewide number of entry level positions.
2. New programs and/or an increase in entry positions in existing programs shall be encouraged by the HECC to replace programs being discontinued or reduced, in order to maintain the Fall 1972 level of entry positions.
3. In order to improve accessibility, new programs shall preferably be located in areas presently underserved by nursing education programs.

*The Planning Process*

1. The Nursing Education Advisory Committee, under the auspices of the HECC, shall have continuing responsibility for making recommendations for nursing education policies. The committee shall include representatives of all sectors concerned with

the education of nurses and the delivery and utilization of nursing services. The committee's responsibilities shall include the periodic review and updating of the planning process.

2. Staatewide and regional health planning organizations shall be involved in the planning process. These shall include the Comprehensive Health Planning Program, the Community Health Education Consortia, the Minnesota Board of Nursing and HECC.
3. The Minnesota Board of Nursing shall continue to fulfill its reponsibility, as charged by the Legislature, for review of new programs relative to curricula, faculties, and clinical facilities.
4. A data base shall be maintained, providing up-to-date information regarding nursing education resources and capacities; current enrollments and student pools; employment of and demand for nurses, and other appropriate information projected far enough into the future to allow for intelligent planning.
5. An annual review of data shall be conducted to provide the basis for recommendtions for the coming year.
6. Criteria for program review shall include the following:

a) Numbers of program entry positions shall contribute toward maintaining a balance between supply and demand for nursepower.

b) The geographic distribution of new programs shall meet the HECC criterion that "relevant programs should be as accessible as possible to all potential students . . . [consistent with] (1) maintenance of high quality, (2) economy of effort considering relative costs of duplicative programs, and (3) the judicious use of resources to meet the total needs of the state for post-secondary education."

c) The ratio of the different educational levels of R.N. programs—that is, the proportionate division among Baccalaureate, Associate Degree, Diploma and Practical Nurse programs—shall be consistent with recommendations of the Advisory Committee.

In addition, the Report shows that ACNE set the course for further coordination. It recommended two additional studies. The purpose of one would be to determine behavioral differences between services performed by nurses educated in the several levels of nursing programs. The other would audit performance expectations among nurses trained at these levels. Objectives of these studies would include fixing criteria for arriving at acceptable service ratios between different levels of nursing education and planning for nursing education enrollments which are compatible with these ratios.

The committee also laid a foundation for addressing other pertinent issues such as career mobility, transfer of credits, continuing education, specialization, clinical station priorities, upgrading of programs, training of nurse educators, interstate reciprocity, and improved communication.

The Commission reactivated ACNE in August of this year. It will review the previous policies, based on current data. Two years of actual data since the original study prove that the predictions were accurate at statistically significant levels. The committee is now establishing measurable goals for its work, consistent with the course proposed in 1973.

In addition, the committee now includes representation from five innovative projects in curriculum design and career laddering in the hope of avoiding unnecessary duplication and of creating reinforcing inter-communication and advance informal evaluation by participating boards. These efforts, done in concert statewide, have the potential not only of loosing some of the age-old knots in nursing education, but also of presenting a state profession united before external review bodies.

Finally, through the inter-agency cooperation mentioned at the outset and assisted by two recent grants, the HECC staff is moving to design and establish local and regional health planning groups, including mini-ACNE's, to stimulate necessary planning and coordination at sub-state levels, that is, between the bases of pyramids.

In short, Minnesota does possess the nursing committee proposed for each state by the report of the NCSSNE but not quite in the form recommended.[9] It avoids master-planning but emphasizes a process that is at once reiterable, continuing, and cumulative. It walks on the two legs of data and expertise animated by the body of a process accepted as having integrity. It is joined at the head to a board-coordinating board at the highest level of state government. This head expresses policies that simultaneously become planning guidelines for institutional faculties and administrators and accountability criteria for governing boards, state and federal agencies, the governor's office, and the legislature.

## References


1. *Report of the Allied Health Personnel Task Force*, State Planning Agency, Comprehensive Health Planning Program, St. Paul, Minnesota, 1973; and HECC Minutes, June 28, 1973.
2. *Report of the Allied Health Personnel Task Force, op. cit.*
3. Minnesota Statutes, Chapter 136A.04.
4. Minnesota Higher Education Coordinating Commission, Proposal for Progress: *Guidelines for State Policy and Comprehensive Planning of Post-Secondary Education*, (St. Paul, January, 1969), 67-72.
5. *Inventories of Minnesota Post-Secondary Instructional Programs*, Research staff of the Minnesota Higher Education Coordinating Commission, April 1972.
6. *Development and Implementation of a Comprehensive Coordinated Health Manpower Planning Network in Minnesota*, HECC, under Contract No. 295-74-0006 with the Department of Health Education and Welfare, Bureau of Health Resource Development, 1974.
   *Project to Develop Planning Policies by Educational Field for Health and Health Related Programs*, HECC, under grant by the Northlands Regional Medical Program Inc., 1974.
7. Board of Nursing Minutes, August, 1974.
8. *Planning for Nursing Education in Minnesota*, HECC, St. Paul (in press).
9. See Report in Introduction To Planning Report 12, *An Abstract for Action*, National Commission for the Study of Nursing and Nursing Education, New York: McGraw-Hill Book Co., 1970, 107.

# Nursing Education Today and In the Future

*By Irene S. Palmer, Ph. D., R.N.*
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With the wisdom gained from a historical perspective, I must comment on the variations extant in today's educational milieu. No happenstance occurrence, the multiplicity of educational avenues is a direct result of response to pressures for numbers or quantity in the face of disregard, disdain, or disinterest of university administrators, the inflammatory anti-intellectualism and pseudo-professionalism present in nursing for the last twenty-five years, to say nothing of the omniscience and omnivorous appetite of some other health related professions. The blessing on hospitals as training grounds for nurses arose when no other financial means of educational survival seemed likely and universities and philanthropists were deaf. This is an endemic phenomenon on our hands. So hospitals opened their doors to the educational process and in accepting the seeming safety of this largesse, nurse educators sealed a fate and carved in granite a system of preparation frought with multitudinous problems.

In describing the history of Boston City Hospital Training School for Nurses, Lucy Lincoln Drown asserts, in 1902, that placing the school under the aegis and authority of the hospital administration was a "first in the nation,"and an honor. Twenty-five years later in an address to a graduating class she raised the question of the wisdom of the action.

The nature of the support, or the lack of it, received by nursing in university medical centers speaks for itself when cost containment is under scrutiny, in invidious comparison to the prestige and status university presidents accord medicine.

That Goliath must be reckoned with, particularly since with increasing frequency physicians are appointed to key administrative positions in university systems. It is not uncommon for a dean to be told by one of these paragons, "The school of nursing must be changed," and when the dean asks, "What would you see the school changing to?" the dean gets the response, "I don't know, maybe train graduate nurses, A.D. or practitioners or something!" It constantly amazes me to learn the extent to which physicians are endowed with encompassing universal knowledge for any key controlling position.

The fragility of any educational system is subject to controlling authority. The educational systems in nursing are not helped by our lack of understanding about the nature and purposes and responsibilities of a profession and our own inability and unwillingness to sacrifice our biases of the past for the professional generations yet to be born and the persons they will serve. It is a puzzlement to me why we should encourage, scrimp, and save to send our daughters, sisters, and sons and brothers and husbands to college, but when someone wants to be a nurse usually we refer them somewhere else.

Past systems of education for nursing have done precious little about inculcating openmindedness, a capacity to see the significance of world-wide happenings to the profession, and the import of current events and trends upon our futures. The existing dearth of leadership potential for key positions in all walks of nursing can also be attributed to a faulty system of preparation. By and large the majority of us working today lack the vision and perspective to shape our world and our place in it. While it may be asserted that those in strategic positions have this quality, a questionable presumption, the young professionals swelling the ranks must be fostered and nurtured and given opportunity and support in designing and implementing innovations and dreams. Deprived of the opportunity, they will settle too soon into the sacred status quo, and society and nursing will have lost the formative effect of progressive youth.

In his introduction to the Golden Anniversary Issue of the *Saturday Review*, Norman Cousins identifies the peril that besets those who dare to predict, specifying that an indomitable human spirit is a vital intangible in shaping man's affairs. He asserts man's inability to predict the cultural economic and social chaos in which the world found itself between 1914 and 1950, and the perservering effect of inspirational leadership exerted in the face of inevitable calamity. He refers to Arnold Toynbee's point that the greatest of all historical forces are set in motion when people decide to pit themselves against serious challenge. The ultimate value of inspirational leadership is the enhancement of self-confidence in the people led.

Mankind's self-confidence is threatened today by global predicaments of paramount import. Major crises may be presumed to be overpopulation and a shortage of food, ineffective world peace, overabundance of nuclear weaponry, contamination and depletion of the world's natural resources, and the impact of scientific and technological discoveries and advances upon the quality of life.

Toynbee declares that the way a people respond to crises is a most valuable variable. Since man is an open system and human experience is an intangible force in shaping man's destiny, then the way we respond to challenges, threats, or fears confronting us makes the future either dark with despair or bright with promise.

I should like to propose three tenets for my paper, taking these postulates from the global threats aforementioned and addressing them in regard to nursing education.

Proposition 1. Socio-cultural-biological man attains self-actualization most fully when he is part of a well-defined social structure.

Proposition 2. The improvement of the quality of life is the most significant social obligation facing man today.

Proposition 3. Contributions to the enrichment of life are the most important function of science.

The current dilemma in health care services confronting all of society assuredly defeats man's self-actualizing attempts. The lack of a well-defined social structure in health care and in educating health workers is as much the fault and responsibility of organized nursing as any other group of providers in the system. In support of this allegation one can point to the several

systems of preparing nurses with varying programmatic names coupled with the same credentialing or licensing examination.

A profession which chooses to remain a profession, to fulfill its claims to professional status, rightfully assumes its inherent obligation and responsibility to differentiate, describe, and distinguish the kinds of workers engaged in the practice of the profession. Society would have a lot less difficulty in knowing what nursing was about, the achievements, capacities, capabilities, and qualifications of the members of the profession, were licensing examinations structured to qualify a nurse according to her preparatory educational program. Nursing has never done this. It has never assumed its rightful responsibility in this area in its entire history! How can we say we serve the social good when society doesn't know who is eligible to provide professional practice. For longer than I care to remember we have fought bitterly among ourselves about the need for education; about the word "professional" with little regard for its true meaning and less respect for our integrity, since we have foisted off on the citizens of the world a product falsely labeled.

Lest you think I hit hard at this confusion, let me quote, "As you sew so shall ye reap!" Much of the attack that nursing is now being buffeted by is a function of the divisiveness amongst us, of our inability to be honest with ourselves and to seize the initiative to close ranks; to move nursing education into higher education; to think less of our own status and to think more of the future nurses who will inherit our problems.

With great hope I await the time when the nurse is clearly identified not only through educational programs but by licensing and the credentialing functions of the nursing organization.

All of nursing must face this issue. Had we the courage to tackle this problem, those external to nursing would have one less handle by which to twist us apart. Certainly we would not have the Chancellor of Higher Education in New Jersey asserting to the members of his Board as well as his counterparts across the nation that, "The professional licensure requirements do not differentiate between different educational levels," and hence he questions the need for a 'generic' four-year program, when it can be done in lesser time." Nor would he be in a position to assert that competency in bedside nursing is no greater with one type of preparation than with another. Nor would the Chancellor be able to assert that the nursing results from any of the three programs, A.D., diploma, or Baccalaureate, is so similar that all that is needed is a greater concentration or depth in basic sciences and skills necessary for an "expanded duties practitioner."

To refer to the proposition that self-actualization is maximized in a well-defined social structure, let me focus on another aspect of the problem of not having differentiating licensure. The utilization of nurse workers is a matter largely between the employer and the nurse employee. Duties and obligations are not distinguishable by title. It is common knowledge that employers substitute one type of nurse worker for another. What is distressing is the culpability of nurses who share in this deceit, as administrators of nursing services and as employees, and as educators who have been unsuccessful in imbuing a true sense of professional commitment to the learner.

It would seem, then, that any attempts to effect a solution to this dilemma would involve clearly differentiating educational programs, all of which would be in the system of higher education. Nursing educators must organize curricula in the programs preparing for nursing practice so the behaviors of the products are clearly distinguishable; a corollary is that the license the graduate would obtain would represent her background and indicate to employer and public alike the services they may expect of her.

Another facet of the need for a well-defined structure which facilitates self-actualization is a system for licensing or certifying the various kinds of nurse practitioners in practice as well as those in the wings. Nursing must come to grips with an understandable and rational basis for preparation and licensure of nurse practitioners. The educational basis for practice in this role must be defined and accepted and adhered to by the profession. We have a multitudinous proliferation of practitioner programs in all guises of education. Standardization to achieve quality performance for the safety of the consumer is essential.

One might logically expect that nursing will have incorporated as expediently as possible the capacities for practitioner services into its curricular offerings. Since the nurse practitioner role is in actuality a *nursing* role, the nurse requires a sound, broad knowledge of social-cultural man and an understanding of human behavior, or else we will have an additional group of technological automatons on the health horizon. The nurse's future role demands more than just skill in health-medical-sickness screening, diagnosis, and referral and an ability to synthesize data from multiple inputs like lab, x-ray reports, physical examinations, and interviewing, to name a few. Lacking a comprehensive theoretical background coupled with a tutorial practice, the nurse will be attuned to the body and not the human spirit. The consumer will receive no better care than the mechanized, impersonal treatment he receives today. Nursing must continue to combat mechanization with compassion and humaneness.

With a more clearly delineated system of educating, differentiating, licensing services, and utilizing nurse workers, the possibility of restructuring health services into primary, secondary, and tertiary health care programs is in the offing.

Surely no one would dispute nursing's long history of efforts to improve the quality of life, which was the very reason for the birth of organized nursing. Leave us not be self-deprecating now, but rather, accept that the greatest problems facing mankind today are our greatest avenues or vehicles for continuing our social obligations as a profession. We must harness ourselves to the tasks.

Educational programs will continue to become more fluid, that is less stereotyped, while increasing their vigilance over the quality of the student's practice, placing increasing burdens of responsibility for learning upon the student, and enhancing the true tutorial nature of the teaching-learning process, so the mind of the student is expanded as well as her role. It is imperative that we provide the intellectual environment and operational climate for the student to develop mental acquisitiveness, synthesis, and integration as habits which will last through her life. The capacity to think, to contemplate, and then to act is essential.

Another aspect of the concern we have for the quality

of life is a recognition of social needs for various kinds of nurse workers. To this end I should hope we would have local, regional, and manpower predictions and estimations according to worker differentiation. I would also trust that before the millennium we would have some kinds of systematic plans for preparatory educational programs.

We can no longer afford the expensive duplication of educational facilities so that every neighborhood has its own school of nursing, anymore than society can afford that every community hospital have all the equipment of an academic medical center. The sharing of facilities, human and physical resources, can be advanced by technological developments in communication as well as by nurse faculty who choose to put aside their own vested interests. While I staunchly believe that learning takes place in a variety of situations, internal and external to academia, I adhere to the philosophy that such learning leads to variations in capacities, skills, and capabilities. Therefore, some system of calibration must exist and be defensible, usually in the form of eqivalency or qualifying testing.

Perhaps still another form of sharing will develop in identifying priorities for the use of clinical facilities. It's heartbreaking to know that practical nurse students and diploma students have priority over baccalaureate students, when the baccalaureate student enrollment is so high, with applicants on waiting lists and with so many demands for these graduates. Is it possible for nurse educators to establish some workable priorities so the nurse with the greatest capacity for affecting the quality of life can be accommodated? Where is our commitment to the educational basis of a profession? If nurses don't believe in the value and necessity of education they ought to practice something else! Even an auto mechanic requires know-how. It is horrifying to implement "open curriculum" and "open access" and "career mobility" concepts in nursing education in the press of closed admissions and limited enrollments because of a dearth of accessible clinical facilities, especially in a medical center. Did you ever contemplate why medicine or dentistry or engineering don't have these opportunities?

Certainly we will see curricular changes which will enable the nurse to develop greater civic and social awareness. The nurse will have bilingual skills, and increased sensitivity to and skill in operating in the political arena. She will be familiar with participating in the electoral and legislative functions of government; she will have a sophistication for working with elected and appointed officials, and for being one! Curricula will enable her to become proficient in political science, government, politics, history, law. She will recognize her power as a woman, and join with other women as a social force. As politicians have "unity" breakfasts, so might we. We must not discount the corrective as well as formative influences of education; young nurses will be encouraged to visit legislators, serve on governors' councils, campaign for office, and speak out on social issues. I envision a senior elective where the student serves as a senator's or governor's campaign or legislative aide.

So that nursing may fully realize the significance of contributing to the enrichment of life and capitalize upon opportunities for affecting man's welfare, nursing education will ingrain, imprint, and imbed research skills, practices, and habits into its students, from the beginning of their educational ventures. Students will be encouraged and helped to develop and carry out studies and research projects which will have some relationship to the world of knowledge on which nursing science is based.

What leadership action can nurse educators and State Boards of Nursing embark upon? Can we separate the judicious use of power and authority from political control? Can State Boards operate so as to insure the equitable use of clinical resources; to measure education in learning and behavior, not only in units of time; to control the numbers of programs and their location in accord with human and physical resources as well as with need; to act as a unifying agent or force with state associations, schools, service after and colleges to assert and assure nursing's place in government, education, society and health services; to move the public against the rages of unwise reform?

The scope of our challenge is great. Problems can be grasped as opportunities. Can we harness enough energy to correct educational systems so we more closely parallel educational patterns of other respected professions? To do so means countless heartaches and also unbounded opportunities to improve and enrich the quality of life and a social structure with which we are bound by our very purposes—the health of mankind.

# The Professional Association's Responsibility For Nursing Education

*By Hazle Blakeney, Ed. D., R.N.*
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Education and organized nursing have been inextricably intertwined since the era of modern nursing began. The nature of the involvement has not been consistent over time in terms of either quality or degree, but is has been unceasing. I would like to begin my remarks by setting the historical stage of this relationship.

The efforts of pioneer nurses such as Sister Helen, Linda Richards, and Miss Eliza Perkins were vigorous and telling, antedating as they did the organization of a professional association for nursing.[1] As the numbers of trained nurses increased, rudiments of organizations were taking form. Some of these organizations were local alumnae associations of particular schools; others were federations of alumnae associations covering geographical areas of states. Although an abortive effort to form an association of nurses on a national level occurred in 1886-1887, the World's Fair in Chicago in 1893 provided the opportunity to initiate the move.[2]

Nurses met during the World's Fair as the Nursing Section of the Congress of Hospitals and Dispensaries. This section was chaired by Isabel Hampton, of whose work Nutting and Dock said:

> In the programme of this section . . . may be found the seedlings of almost all the later lines of growth in the nursing profession in the United States.[3]

I think you will agree. Miss Hampton read her paper on the three-year education program, in which she recommended affiliations to insure varied learning opportunities for nursing students. Miss Hampton assigned the topic "The Necessity for An American Nurses' Association" to Miss Edith Draper, who, not being really enthusiastic about the idea, prepared her paper with an emphasis which siphoned off the strong impetus for the development of the association. Miss Hampton held her ground, however, and a committee was formed from among the nurses present to draft a constitution for the American Society of Superintendents of Training Schools for Nurses. The organization was born in 1895.

The determination and commitment of the nurses comprising the organizing group was described in the following manner:

> . . . a more high-minded group of women could not be found, or one more free from self-seeking. Their thought was ever how best to fulfill the three-fold obligation to the hospital, their pupils, and the public. There was no attempt to grasp at power for its own sake, but only to protect standards of work and ethics; no smallest desire to retain control over graduate nurses, but only to equip and prepare them for self-government. The occasional member whose outlook was small never rose to prominence, nor did her views carry. An altruistic band of leaders and teachers, encouraging their alumnae groups to self-development.[4]

In 1897 the Nurses Associated Alumni of the United States was formed. Education prospered under the guardianship of the organization. Advanced courses in the teaching of nursing and administration were arranged for and offered at Teachers' College, Columbia University. The Helen Hartley Jenkins chair was endowed at Teachers' College; three-year programs and eight-hour days were being placed in force in several hospital schools, although acceptance of the eight-hour day lagged behind the lengthened program. The practice of sending students out as private duty nurses was soundly criticized and was largely abandoned.[5]

In 1917, the Certificate of Incorporation of the American Nurses' Association included the following statement: ". . . to promote the professional and education advancement of nurses in every proper way; to elevate the standards of nursing education."

If nursing is to exercise its rightful, autonomous prerogatives, then it *must* set forth the standards and conditions which govern the educational system through which the members of the profession are prepared to practice.

Myron Leiberman cites eight characteristics of a profession. Each may represent the profession as a collective, but two of the characteristics he mentions have special significance for the organized structure of the profession. He notes that a profession is characterized by "a broad range of autonomy for both the individual practitioners and for the occupational group as a whole," and that it is marked "a comprehensive self-governing organization of practitioners."[6]

Other characteristics of a profession are pertinent here. Leiberman states that a profession places "an emphasis upon intellectual techniques in performing its service."[7] The delineation of these intellectual processes and their refinement require intellectual operations, and the performance of a "unique, definite and essential social service" depends upon the practitioners' competence to define the problem, garner relevant data, and discriminatively select those data which illuminate the problem at hand. The outcomes of decisions made have the possibility of such grave consequences that practitioners need long, arduous education[8] to attain the knowledge and the functional intellectual abilities required to cope with complex and complicated medico-social-psychological problems.

Professional knowledge, as a function of its "uniqueness," consists of a body of highly specialized information; the client, therefore, is placed in a highly dependent relationship with the professional. The professional must accept "broad personal responsibility for judgments made and acts performed with the scope of professional autonomy."[9]

Given the kind of service rendered by nurses, the depth of knowledge required to render that service, and the vulnerability of the client in the face of the autonomy provided the professional worker, I believe I have justified the position that the professional organization—any professional organization—*ought* to assume respon-

sibility for the nature and quality of the education of its practitioners.

Having viewed the imperatives from a broader context, let us examine the way in which the American Nurses' Association fulfills its responsibilities. The American Nurses' Association acknowledges responsibility to set standards and exercise leadership in influencing the direction and course of nursing education. Perhaps never before in its history has the Association moved so aggressively to assert its authority and responsibility for nursing education.

Under the present structure of the American Nurses' Association, the Commission on Nursing Education serves as the "education arm" of the Association and is therefore mandated by the Bylaws [1] to establish the Association's responsibility for education. As you know, the Commission has published a number of statements of position regarding education. Another responsibility mandated by the Bylaws is to develop "standards of nursing education and devise methods for gaining their acceptance and implementation through appropriate channels." [1]

The Standards for Nursing Education have been prepared and a draft statement has been presented to the profession. Feedback is coming in and we hope to have the Standards ready for printing following the next meeting of the Commission.

In collaboration with the Association's Council on Continuing Education, plans are moving forward to comply with the directive of the 1974 House of Delegates to accredit continuing education programs. The Association is responding to its responsibility to insure the competence of practitioners. Continuing education is one way to maintain competent skill levels.

Also in response to the will of the 1974 House of Delegates, the Commission on Nursing Education is giving leadership to developing the feasibility study for accrediting basic and graduate programs in education in nursing.

Exploration is being carried out and budget is being requested to underwrite some regional meetings on implementation of standards of nursing education. The Commission believes the standards are appropriately broad so that faculties can design a variety of curricula and at the same time do no violence to the standards.

The services of nurses fill a societal need, and the Association takes cognizance of that fact by formulating policy and recommending action concerning federal and state legislation in the field of education. Commissioners have participated in the "Cost Study of Education of Health Professions" [2] and have given testimony at congressional hearings regarding the Nurse Training legislation. The Commission on Nursing Education, along with ANA staff, have conducted small studies for the purpose of updating information which might be used to support or otherwise influence legislation in nursing education.

Other legislative concerns are monitored, and the implications of these matters are translated into implications for curriculum content. The evaluation of "relevant scientific and educational developments, changes in health needs and practices, with reference to their implications for nursing education" [3] is carried out and findings are communicated as having import in curriculum adjustment.

Concerns about nursing education are legitimate concerns of the Commission on Nursing Education, on behalf of the American Nurses' Association. The Commission is party to an Alliance with the American Association of Colleges of Nursing. Both groups have legitimate concerns which may possibly overlap. Through collaboration resources may be used economically and duplication of effort avoided. The tasks of nursing are many, costly, and crucial. We can ill afford to be wasteful of nursing resources or energies.

I think I say honestly and with some pride that we have addressed each of the Bylaw-mandated responsibilities, except the one on encouraging and stimulating research in all areas of nursing education. Some of our efforts have, of course, been less productive than others, but we are trying, and we will improve in the process. Perhaps in the professional organization, as in the larger society, practice will precede law. In any case, we believe that there is a need for more planned interaction between and among structural units. Already a member of the Commission on Nursing Education is working with a Committee from the Commission on Nursing Research to set up guidelines for research preparation at the doctoral levels.

More cross-fertilization should be occuring between the Congress for Nursing Practice, the several practice divisions, and the Commission on Nursing Education. Almost all the practice divisions have developed their standards. These standards must be translated into practice models for the practice areas, but those same standards need to be incorporated into the curriculum of basic or graduate formal programs, continuing education programs, or possibly both.

There remain some further efforts to be made. More collaboration is needed with health care delivery practitioners for utilization and evaluation of graduates of different types of nursing programs. There is also a need to have interchange with the Council of State Boards of Nursing, so that educators are aware of the kinds of problems the State Boards encounter. Perhaps the educational process could provide experiences which would ameliorate these problems.

Since we are dealing with "The Professional Association's Responsibility for Nursing Education," it would be instructive to look at the proposition that in the area of education we are concerned with not one, but two occupations in which professionalization is being sought through many obstacles—obstacles imposed upon us and obstacles resulting from our own ineptitudes.

Any group which, implicitly or explicitly, is unclear about its functions and responsibilities may expect other groups with axes to grind to step in and define the group's functions. Educators and nurses as professionals are frequently beset by these visionaries. As nurse educators, we get it from both sides.

It is difficult to plan or establish a conceptual framework for a curriculum if our staus relative to autonomy is operationally questioned or challenged. If, as nurses, some of us are pressing to develop and be recognized for our unique and independent functions, and others of us feel that such aspirations are ego-based and nursing's appropriate function is to support and assist the physician and *his* plan of care—program planning is likely to be schizophrenic, at worst, and our graduates are likely to be at odds with employment opportunities, at best.

I believe some of the discontinuities which exist between educational preparation and role fulfillment are due to unspoken philosophical disputes over the concept

of autonomy.

Leiberman exhorts educators to stake out their territories where decisions should be made by the trained expert of the field. [14] While acknowledging the fact of accountability to the public for outcomes, he contends that it violates the professional autonomy of the educator to have the laity make decisions which are the responsibility of professional educators. He states, "Teaching not only relinquishes but actually encourages lay determination of its functions." [15] An unexamined view of democracy is frequently the "spoiler" in creating these interferences. We have damaged the axiom that one should participate in decisions which affect him. A more responsible attitude would be that individuals should participate in those decisions in which they can make a contribution. To seek the consent and approval of laymen on matters requiring professional expertise undermines professional autonomy and is neither democratic nor professional.

Truly professional people will not take an arrogant self-serving attitude. Professions are characterized by their social consciousness. A spineless abdication of professional, autonomous responsibility is no more to be lauded than an arrogant, "know-it-all" one.

Faculties should have their consciousness-level raised in relation to on-going research and research findings. We now have validated research findings which if disseminated and approved would make our programs more responsive to students' needs, more dynamic to hold their interest, and more challenging in preparing students to meet clearly mainfested needs.

I believe it is high time that we tackle in our educational programs—on all fronts—the teaching of values and give attention to attitudinal changes. I am saying this as forthrightly as I can and totally without apology. So much lip service is given to "relating," to interpersonal relations or self-actualization, and yet the quality of relationships seems poorer than they have ever been. It is by all authorities a difficult area in which to try to work. So, the difficult we can do—it is the impossible that takes a little longer.

Finally, I would like to express commendation to this Council of State Boards of Nursing for what I view is your wisdom and good judgment in being supportive to both the idea and fact of innovative programs in nursing. On the other hand, I would raise this question: What power does the licensing board have for curtailing the opening of programs operating on unsound educational premises?

I hope you will raise questions with me so that I may carry your concerns to our Commission on Nursing Education for stimulation and challenge.

**References**


1. Nutting, M. Adelaide, and Lavinia L. Dock. *A History of Nursing* II. New York: G. P. Putnam's Sons, 1935, 370-435.
2. *Ibid.*, III, 125.
3. *Ibid.*
4. *Ibid.*, 127.
5. *Ibid.*, 129-137
6. Leiberman, Myron. *Education As A Profession.* Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1956, 1-6.
7. *Ibid.*, 2.
8. *Ibid.*, 4.
9. *Ibid.*, 6.
10. American Nurses' Association. *Bylaws* Article XII, Sect., 7(b), 18.
11. *Ibid.*, Section 7(d).
12. Institute of Medicine. *Costs Of Education in the Health Professions.* Washington, D.C.: National Academy of Sciences, 1974.
13. ANA *Bylaws* Article XII, Section 7(a).
14. Lieberman, *op. cit.*, 87-123.
15. *Ibid.*, 98.

# The Role of The State Board of Nursing In Post-Basic Nursing Education

*By Patricia A. Wagner, R.N., Department of Nursing, DePaul University*

I have been asked to discuss the positive side of the proposition that State Boards of Nursing assume responsibility for approval of programs in nusing beyond those providing for pre-service education which leads to licensure. Included would be programs preparing nurses at the master's and doctoral levels, as well as those that prepare the practitioner for expanding roles, non-generic baccalaureate programs for the registered nurse, and other educational programs designed to meet the nursing needs of individual states.

There are many schools of thought on such a proposal. In order to approach it from a realistic level, I felt it necessary to set some limitations and to scale it down somewhat to a size more reasonable for consideration. To assume even a small degree of expertise in such a complex area is somewhat presumptious. I feel I must draw on some of the experiences I had as a member of a State Board of Nursing and present one viewpoint, knowing full well that many may feel that the situation has been over simplified or perhaps is in conflict with the principles of academic freedom. For purposes of this discussion, I choose to interpret "education beyond the preservice level leading to licensure" as any form of education or learning one acquires after beginning practice as a registered nurse. This can include formal education, such as completion of requirements for baccalaureate, master's or doctoral degrees, or other means of continuing education presented in less formal settings and described in a variety of ways—such as workshops, institutes, self-directed study, research activities, publications, and the like.

Thus in this fashion, I will be considering the role of the State Boards in the approval of those programs which provide for continuing education in the field of nursing. That activity, in effect, determines to some degree whether or not current holders of the nursing license do meet standards of competency, even though they may have formally demonstrated this many years before through successful achievement on the State Board examination.

I prefer to use the word "approval" rather than "accreditation" so that in discussing the activities of State Boards we are consistent with the nursing acts and regulations. According to the Report on Licensure and Related Health Personnel Credentialing, accreditation is defined as a "form of regulation or control that is exercised over educational institutions and or programs by external organizations or agencies. It is developed in this country as a procedure of voluntary self-regulation by peer groups of educators and members of the respective professions." [1] Since this definition specifies voluntary action rather than mandatory action, it is more appropriate to use "approval," since the educational programs involved must meet state standards or they are not permitted to exist. Most of the state nursing practice acts include the maintenence of a list of *approved schools* as one of the responsibilities of Board members.

For purposes of focus, I want to review some facts about nursing practice acts and licensure. We all know the rationale given for the existence of these. The states have sovereign power to impose limitations or to regulate the practice of professions in areas where the health and welfare of the public are concerned. Through licensure the states seek to protect the public against incompetent and/or illegal practices. By definition, licensure is the "process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety and welfare will be reasonably well protected." [2]

Of late, there has been a great interest in licensure laws at both the state and federal levels. Various groups have become actively concerned about laws that affect the practice of nursing, medicine, and dentistry, as well as other health professions that license practitioners. Consumer groups have become especially involved in this activity. Many see licensing laws as serving the individual professions by keeping control of the entry mechanism and protecting those already in the profession, even if not competent, rather than serving as a protection of the public interest. They also view the idea of a one-time determination of competency which confers licensure for a lifetime to be most compatible with the knowledge and technological explosions of the recent past, the present, and the future.

We are at that point in time when the doors are being steadily beseiged to permit entry of assessment of continuing competency as a requirement for re-licensure of all health professionals. The mechanism being utilized more and more is the coupling of continuing education with renewal of license. There are many arguments pro and con on this issue, with the pro side usually supported by lay groups greatly affected by the practice of health professionals and the con side most often represented by the professionals themselves. All concerned usually concede that mere exposure to an educational experience does not guarantee that learning has taken place, but likewise, one must also concede that if one is never exposed he most certainly will become static or indifferent at worst, or maintain the status quo, whatever the level, at best.

It would seem reasonable that this is where the state-created mechanism—the State Board—could continue to serve both the public and the profession by determining what keeps the nurse competent to practice nursing.

In each of the 50 states, nursing practice acts have some components in common—they all define professional nursing, stipulate requirements for licensure, and indicate procedures to be followed for transfer of license from one state to another (usually through endorsement); they outline conditions under which suspension, revocation, and/or refusal to renew licenses may occur; and, importantly, they provide for a board or committee of examiners, and specify their duties and responsibilities.

In effect, State Boards of Nursing have been determining standards for schools of nursing that are tested

through licensure examinations. The Boards also determine if these standards are met by the practicing nurse by administering the powers and responsibilities delegated to them by the nursing act to revoke, suspend, and/or refuse to renew licenses. The Committee on Standards of the ANA Council of State Boards of Nursing, in its "Guidelines for Developing Legal Standards for the Practice of Nursing," states "It is now imperative that boards of nursing assume the responsibility to further protect the public by stating standards of practice that interpret the legal definition of nursing as well as provide criteria against which violators of the law can be determined." [3] In the development of standards, the Boards were reminded that such standards "shall require appropriate preparation for continuing competency and for the assumption of advanced practice roles." [4]

So by their very appointment and performance of specified duties, the State Board members are making determinations of minimal competency as well as certain specific judgments of what constitutes continuing competency in nursing. There seems to be no real argument about the role of the State Boards of Nursing in determining pre-service educational standards. There may be some dispute in regard to some of the specifics, such as the extent and limits described in the rules and regulations for the implementation of the nursing practice act, but these difficulties can usually be worked out satisfactorily. However, this leaves quite a few nursing education programs outside the Board's jurisdiction, if the interpretation is limited to just those schools and programs preparing for licensure. Again, the question arises, can or should the State Board of Nursing be involved in granting approval to programs that go beyond the pre-service preparation and education of nurses?

All of you who were at the 1974 biennial ANA Convention in San Francisco can attest to the attention given to continuing education. The House of Delegates deliberated over many positions dealing with voluntary versus mandatory continuing education. The House took significant action in regard to resolutions submitted, leaving out both the words "voluntary" and "mandatory" in the final statements accepted. One Resolve read:

> that ANA reaffirm support of continuing education programs and that state nurses' associations move forward to strengthen continuing education recognition programs. [5]

Another most interesting and significant action of the House was the recommendation:

> that the House of Delegates direct the ANA Board of Directors to move with all deliberate speed to establish a system of accreditation of continuing education programs in nursing and that ANA move just as expeditiously to examine the feasibility of accreditation of basic and graduate education. [6]

In regard to the former, concern was being expressed that in many states legislators were becoming more and more involved with making determinations about what constitutes continuing education for nurses because they feel that the profession is dragging its feet in this area. We are all familiar with the positive aspects of professionals assuming responsibility for their own continuing education, but we know full well that all nurses do not act responsibly in this area and most likely never will unless forced to do so by law.

Public interest in the continuing competency of health professionals goes on, and rightly so. If the profession does nothing specific to take care of this matter, it will be done without their assistance, and some of our worst fears have already been confirmed. As nurses, we feel we should be the ones who determine and control our own education. We are astute enough to realize that any closed system becomes self-serving and sterile when deprived of necessary stimulation and nutrition that can evoke constructive change. Working with groups who will eventually write and pass the laws that affect our professional life and thus our practice will, hopefully, allow for a reasonable and workable mechanism in such a vast undertaking as mandatory continuing education, seen as evidence of continuing competency by many outside and within the profession.

In Illinois, we were given a forecast of what the future holds in regard to this very thing. I would like to share it with you, since I am reasonably sure that some other states might have had similar experiences. In response to the recommendations set forth in the document, Report of Licensure and Related Health Personnel Credentialing, and other similar reports, many states initiated studies in the area of licensure of the various health professions. [7] In Illinois the effort was known as the Illinois Health Care Licensure Commission.

In January of 1973, this group issued its findings and these were consequently translated into the *Health Care Licensure Act*. The Commission was interested in making statutes more consistent for all health professionals in regard to the following: creation of state boards; appointment, qualifications and term of office for board members; grounds for removal from office, filling of board vacancies; and general rules and regulations. The Commission was also interested in creating a separate Health Division for all health professionals, in using licensing fees to support the various activities contemplated, and in adding a consumer and one related health professional chosen by the board members to each of the boards. The director of the Department of Registration and Eduction would appoint representatives with the advice and consent of the health associations through the professional association.

In addition, the Commission proposed a regulatory board that would act as an "unbrella" board and consist of one member of each individual licensed health profession plus other appropriate representatives. The duties ascribed to this board in the rough draft were most interesting, among which were rather nonspecific activities dealing with *supplementary* education, and the possibility of this group serving as the *final mechanism for accreditation of health schools within the state*, which in turn might serve as a national model for accreditation of health schools.

The membership of this regulatory board, known in the final draft of the bill as the Health Professional Career Board, was as follows: a doctor of chiropractic, a physician, an osteopath, a dentist, a registered nurse, a licensed practical nurse, a dental hygienist, a sanitarian, a psychologist, a physical therapist, and a funeral director, each actively engaged in the practice of his profession in this state; in addition, a representative of the Hospital Licensing Board, a representative of the Board of Higher Education, a representative of the Junior College Board, a consumer, a representative of the Illinois Association of Public Health Administrators, and a director of clinical laboratory.

Their charge: "To serve as a coordinating body for health professionals in areas of common interest of all health professionals and where the public interest dictates that inconsistencies be minimized or eliminated and to serve as a liaison between the examining committees and the Department." [8] This board was also to consider, adopt, and implement proficiency equivalency standards to health professionals or paraprofessionals so as to foster greater lateral and vertical mobility in the health care related educational programs in this State." [9]

Here is a rather frightening part—this board was to "consider the need for or desirability of supplementary education for health professionals and the accreditation of health care related educational programs in this State." [10] This section of the bill was never fully clarified or explained when questions arose, but in view of the composition of such a board one can imagine just how much control a given profession would have over the determination of the program of studies in either basic or continuing education, e.g. one registered nurse representing the profession's viewpoint among such a diverse group. Although this bill did not eliminate the state boards, it did by implication greatly diminish the scope of the activities of such boards. The bill was defeated chiefly because it sought to regiment all the health professions, but the sponsors vowed to submit similar legislation with perhaps far more reaching effects.

We are all aware of the ANA's Council on Continuing Eduction and the tremendous activities undertaken by the state nurses' associations in response to the national directives. In Illinois, the Council on Continuing Education is in the process of approving hundreds of programs throughout the state, and the response of nurses to these offerings is gratifying. One cannot be sure what impetus has made the acquisition of CERP's a much sought-after thing, but one can hope it is the nurses' own thirst for programs that help them to render more effective, up-to-date care for all the patients they encounter.

Constructive collaboration betrween the state nurses' associations and State Board members is greatly needed. Much of what is being done by the associations could prove very helpful to the state boards when they are faced with similar activities. Experience in working out the problems in a voluntary system may help in coping with the reality of a mandatory system. Through the efforts of the state associations and the State Boards, areas of domain can be established which allows the profession to put forth a cooperative effort that indicates that nursing recognizes the need to keep the practice of each nurse at the optimum level and to ensure that the recipients of nursing services are being provided with some assurances of competent care. In this way nursing will maintain control of its own professional educaton and can demonstrate to the public that the profession has taken steps to keep nursing knowledge current. It is urgent that those most qualified by virtue of expertise, interest, position, and professional committment be placed in a position to help draft legislation that will affect the professional lives of thousands of nurses.

In keeping with the directive to me, I make this proposition:

Since the State Board of Nursing is legally designated to set and maintain standards for initial competency at the entry level into nursing, through the mechanism of the State Board examination, and since the Board also has the authority to revoke, suspend, and/or refuse to license or renew a license once obtained, it seems reasonable that this same State Board of Nursing is the logical body to determine how practitioners continue to remain competent to practice professional nursing in accordance with laws that require evidence for relicensure.

This can be accomplished by Boards assuming responsibility for approval of continuing education programs in nursing—including formal academic programs at the baccalaureate, master's and doctoral levels, as well as other programs in continuing education which are (or will be) mandated by law as a means of evaluating continuing competency to practice professional nursing.

*RATIONALE*

1. The State Boards are recognized as the legally constituted body delegated to deal with the practice of nursing in the area of determining competency.
2. Most nursing practice acts already contain provisions for an enlarged membership (with some specifically identifying the representatives based on the types of programs offered in the state, plus consumer and/or allied health professional, if so stated) or would be in a position to enlarge Boards so that they are a more representative group.
3. If (or when) continuing education becomes mandatory for relicensure—and we are all pretty sure that this will happen in the not too distant future—the state must rely on those legally constituted to make decisions regarding continuing competency of the practitioner seeking re-licensure, since the state is the only agency that can grant a license.
4. State Boards are experienced and familiar with standards that determine initial competency. They work together with professional staff and usually have appointments of two to three years duration, so that, as a rule, they are a stable continuing group, familiar with procedures and policies in the state as well as with evaluation of criteria and standards.
5. There would be one established group dealing with professional nursing, the majority of whom are members of the profession, establishing and controlling educational preparation and practice so that professional integrity and autonomy would be preserved. At the same time, there would be input from those interested in and affected by nursing services (the consumer and the allied health professional) not only at the entry level but also in the area of determining continued competency, which is the major concern of the public as well as of the profesion.

I have tried to present one approach or consideration of a very complex and as yet uncharted future happening in nursing in relation to education and practice. Rather than focus on the specifics of formal higher education programs, *per se*, whatever their description, I have put them all into the context of "continuing education" beyond the pre-service preparation for nursing which leads to initial licensure. With the spectre of mandatory continuing education as a requisite for relicensure hovering in the wings, it seemed logical to me that State Boards of Nursing could be utilized to provide for some continuity and sequence in dealing with a very enormous problematic area. I am sure there are many objections that can be raised—some political, some philosophical, some educational, and some professional—to the ideas set forth. If my remarks do

nothing more than create a reaction or serve to generate a completely different answer through complete rejection of the idea proposed, I will have accomplished my objective.

## References


1. Report on Licensure and Related Health Personnel Credentialing. Washington: Department of Health, Education and Welfare, 1971.
2. *Ibid.*
3. Committee on Standards, ANA Council of State Boards of Nursing, 1973.
4. *Ibid.*
5. *The American Nurse*, July, 1974.
6. *Ibid.*
7. Report on the National Advisory Commission on Health Manpower. Washington: U.S. Government Printing Office, 1967.
8. Matijevich, *et al.* House Bill 1414 *Health Care Licensure Act* State of Illinois, 1973.
9. *Ibid.*
10. *Ibid.*


## Bibliography


Eggleston, Martin. "Continuing Education: a Requisite for Professional Membership or a Necessity for Relicensure." *Journal of Continuing Education for Nursing* (May-June, 1974).

Kelly, Lucie Y. "Nursing Practice Acts." *American Journal of Nursing* (July, 1974).

# The Development of Criteria for Accreditation and Curriculum Innovation

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The topics assigned to me to present today were curriculum innovation and the development of criteria for accreditation. In approaching these topics it seemed the second topic could best be tackled first as the standards or criteria to permit innovation must be established before innovation itself can be considered. There are two basic purposes for legal registration/accreditation of nursing programs. The first is the public concern for preparing competent nurses through effective educational programs that use funds judiciously. The second is to protect the students who enter nursing programs by providing valuable education under safe and appropriate conditions. It is against these two purposes that we should measure the criteria we develop for evaluation.

Standards for nursing programs are not static, they need review and revision in light of new factors which affect nursing and nursing education. Some factors and examples of these are:

1. The concept of giving credit for knowledge whenever it was attained.

   Perhaps our first real experience with this was the returning corpsmen after World War II. More recently we have begun to test extensively for previously acquired knowledge and skills. A natural outgrowth of this is that someone, somewhere can pass all our tests and prove that there is nothing in our nursing curricula that he needs to be taught. One long cherished standard is thus outdated: that a school graduating a student should require one year of residence in the program for graduation. This requirement was dropped by the Regents of the University of the State of New York and the State Education Department when the external degree concept was implemented.
2. Another long cherished standard is that only governmental or non-profit organizations may conduct professional programs. Today this standard is being questioned by many (although public monies probably will not be funneled into proprietary schools). If the school can provide quality education and students are willing to pay for it, on what basis do we deny approval of the program?
3. Nursing roles contantly change and the standards developed need to be evaluated to determine if they permit new roles or if they hamper their development.

As state agencies it is important that we determine many facts about nursing programs and the institutions conducting them before giving beginning approval or appraising on a continuing basis. One is the fiscal viability of the parent institution. Another is the resources available to the program, such as classrooms, clinical facilities, faculty, library, student residence, the supporting services to students, such as counseling, recreation, and health services. There are in addition the legal responsibilities of the school, which only the state agency can identify and require to be met. No voluntary accreditation program can force all programs to meet state laws regulating educational institutions.

As a first step in revising standards, assuming that we all have standards at present, we should review current standards and see if they still apply. To do this one should know the reason the standard entered the books in the first place. An example of one standard which we no longer apply or have on our books is that if a school wished to send its students out into the community to do private duty it must extend its programs beyond the minimum two-year length and do so only after the first two years. If the reason the standard was adopted no longer exists, the standard is not needed. Most of our standards in relation to hours of class and weeks or hours of practice were developed in relation to the clinical services in our hospitals. Medical and surgical nursing requirements grew as the services grew and were divided into all sorts of required specialty areas.

The advent of an integrated curriculum based on principles of nursing care has blurred distinctions between nursing in each clinical area. One reason we still use the service areas to describe a curriculum is that the State Board Test Pool examination still uses them. This is continuation of an outmoded standard, with State Boards and educators each waiting for the other to move first. Today we should be trying to determine how to describe standards for the nursing content of the curriculum in terms of the integration of nursing knowledge. Boards and their staffs should be constantly alert to changes which make a standard obsolete, and they should move to revise or drop it whenever this occurs.

The legal body responsible for the development of standards for registration of programs leading to license may vary from state to state. In most states today the legal body is not free to set standards in isolation, However, neither is the profession free to set standards in isolation. In seeking the states' endorsement of licensure laws, the profession had to relinquish to the government a share in this responsibility. In order to obtain the protection of licensure, the profession had to place its preparatory programs and practice within the full legal structure of the state and all that that involves. Even if it were possible for the state to set standards in isolation, it would not be politic to do so. The "others" who are generally concerned as to the desirability of a set of standards include:

1. The faculties conducting nursing programs.
2. The parent institutions where nursing programs are located.
3. The professional association. The professional association cannot expect that all of its suggested standards can be adopted by the state, without modification to fit into the legal system or without consideration of the effect that the standards will have on students, educational institutions, or others concerned. The State Boards and their staffs are public officials responsible to the public as well

as nurses responsible to their profession; therefore both public and professional concerns must be considered.

4. The bodies responsible for funding programs. In our state, as state funds are given to every level of nursing education program, prior to the adoption of new regulations, the legislative body which appropriates funds must be consulted.
5. The consumers. Usually it is not feasible to contact the ultimate consumer, but the agencies employing nurses may be contacted. Legislators, as elected representatives, also represent the public and consumers.

The sources for standards which can be used by those responsible for formulating them are:

—Suggestions from nurse faculties and institutions, as these are received on visit or other contacts with schools.

—A review of standards as stated by other boards, the professional association, other professions, and higher education bodies.

—A review of legislation and court decisions affecting nursing responsibilities, student and faculty rights and responsibilities, and school responsibilities.

—A review of research in eduction and nursing.

One criticism leveled at all accreditation standards is that there is no documentation that the standard is necessary to produce the effect it purports to produce, but merely that the standard is an expression of the judgment of those establishing it. Any validation of standards would be a welcome addition to the process.

Some criteria by which to measure standards are:

Is the standard attainable by a majority of schools or only a few?

Is the standard an absolute or may there be exceptions?

Is the standard essential to meet the objectives or requirements of the law?

Is the standard stated in unambiguous terms, or can it mean different things to different people?

Do different types of nursing programs need different standards, i.e. is the standard applicable only to the associate degree program, the baccalaureate degree program, or the diploma program?

Does the standard have to be stated in quantitative terms?

Is the standard a goal toward which schools should be aiming? If so, is this then a standard or a guide?

Does a standard have to be restated if the law or other regulations contain it?

Does the manual for schools contain, in addition to standards, suggestions for developing excellence?

Overall, is there a rigidity in the enforcement standards, or are the number of absolute standards kept to the essential minimum?

Is the standard defendable in relation to educational philosophy, democratic principles, civil rights of individuals, and so forth?

Is the standard legally enforcible? Legal counsel should review standards and advise the Board regarding this.

Is the standard compatible with standards in higher education in the state, and with other professions in the state?

Are standards which protect the student mandatory? Administration and organization of the school must meet legal standards within the state and have policies which are fair to students; if the Board approves schools which do not have any other state approval standards governing, their conduct will have to be stated in law or regulations.

Are records adequate and are there provisions for the storage and maintenance of records?

Is there a published list of fees and charges to students and a published policy regarding the return of fees?

Do the standards recognize the legal responsibilities of the board of directors, the executive officers of the institution, and the professional responsibility of the faculty, each in their own area of expertise?

When the State Board or staff have developed new standards in relation to the new needs, these should be publicized before they are adopted. Prior to that, they should be reviewed by legal counsel for their conformance to the law. A general principle in relation to the law is that the standard can implement and clarify the law but it cannot supercede it, nor can it be more restrictive than the law. We had a recent example of such an instance where a regulation was adopted that was more restrictive than the law, and it had to be repealed. Another principle is that if a standard is explicit in the law it does not need to be repeated in standards. The law can be referred to as necessary.

Some states require publication of proposed legislation in an official publication, and some may require public hearings to be held. Even before these steps are taken, however, the new standards should be presented to the schools which will have to understand and implement the standard. An effective way to do this is to develop a three-column presentation, with the old standard next to the new standard and a third column to explain the rationale for the change. Every affected institution should be sent copies of the proposed changes and invited to comment on them within a specified time. The comments should be carefully analyzed and a determination made as to whether or not the proposed change can be put into effect by the institutions affected.

Other interested groups can be invited to review the standards also. Some of these may be the professional associations, the hospital association, and other state agencies. A variety of means to effect this may be used, such as meetings with representatives or mailing the standards with a request for comments.

Should there be strong objections to some standards proposed, it is wise to air these in meetings with the parties affected and to attempt to resolve differences.

In New York State, certain standards known as Regulations of the Commissioner and Rules of the Board of Regents must be presented to the legislature before they can be adopted. The legislature's major concern is the budgetary effect. However, individual legislators may have concerns as to the effect a standard will have on their constituents. They have an opportunity to question a standard if they are familiar with the proposal before it is adopted.

In looking forward in light of the trends of nursing education, can we state standards in qualitative rather than quantitative terms? If our objective is to provide a practitioner who is safe to begin to practice as a nurse, can we define the competencies she needs? Does the length of time spent in a program determine whether or not the objectives of a program are met by the student? How has the modular curricula concept affected our con-

cept of terms and semesters? If we adopted statements of competencies as criteria, could nursing education cope with students all at different stages of development and graduate the students when all competencies were attained? Could nursing move to a continuum of competencies for various levels of practitioners, and could we manage such a system for licensing and authorizing various levels of practice? Could we recognize learning in such a program, wherever it took place or would we recognize only formal educational programs? Should we now be concerned with identifying levels of competency for various levels of programs and different levels of practice?

If a model such as this were adopted, the areas of curriculum amenable to innovation could be freely explored. Faculties could develop and test methods of aiding students to gain competencies. The standards which protect students could still be mandated, and the interests of the public in providing safe practitioners would be facilitated. The Boards would then hold the responsibility for ensuring that the innovations proposed were sound as experimental designs and based on sound educational principles and philosophy, not whether they met a rigid standard for content or hours. The Board could also promote the adoption of those methods of meeting objectives found to be most effective and most economical of time and resources.

This model may sound far out, but if one considers the external degree, it is the model we are rapidly approaching.

# Examining Various Approaches to School Surveys and The Role of State Boards of Nursing Education

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Within the administrative responsibilities of any State Board of Nursing are two vital documents or tools for the effective operation by the professional staff and the Committee and/or Boards of Nursing. These tools are the Nursing (Practice) Act and the Rules and Regulations.

The Nursing Act in any state is a statutory document enacted by the legislature, while the Rules and Regulations are policies for the implementation of the Act writ ten by the various Boards of Nurses, and filed with the appropriate state agency before becoming legally operative. Rules and Regulations define a Program of Professional Nursing and a Program of Practical Nursing; provide a framework for the development and administration of educational programs; serve as a guide in determining compliance with standards required of State approved/accredited programs; and in some instances contain the Standards of Nursing Practice.

Educational criteria are promulgated and sufficiently general to provide opportunity for flexibility, program diversity, and changes as new developments in nursing practice occur.

State laws relating to nursing were nonexistent before 1903, but between 1903-1913 at least 20 states enacted legislation prescribing conditions of education and practice. Every state now defines the minimum qualifications of its candidates who aspire to practice nursing. Since practice rests upon education, state laws have been very specific about the preparation of nursing.

Boards of Nursing have held to the concept of guidance as a comprehensive program for the development of described standards for nursing education and for the continuous improvement and innovation of programs of nursing. We believe that program site visits, annual reports, and student achievement on State Board Examinations are important methods for attaining these goals.

While the principles of guidance will be the same for all states, it is recognized that there are differences in the composition of the legally consituted agencies which are empowered to establish and maintain standards for nursing education and practice.

As social, educational, and economic pressures on nursing programs continue to mount, the role of the State Boards of Nursing is being examined with increasing concern. Landmark innovations are taking place in the application of the Rules and Regulations to new kinds of programs and/or new learning situations in nursing education leading to licensure.

How are the Rules and Regulations implemented? They are implemented by evaluating the essential elements of a school of nursing.

In 1949, an appraisal of schools of nursing was published, based on criteria enunciated in two widely accepted works of the profession, *A Curriculum Guide for School of Nursing*, published in 1937, and *Essentials of a Good School of Nursing*, published in 1942. On the basis of the minimum standards supported by the profession in these publications, then seven to twelve years old, a total of 1,147 schools were appraised. The criteria related to the following areas: admdinistrative policies; financial organization; faculty; curriculum; clinical fields; library; student selection; and provision for student welfare and student performance on state board examinations.

Now, in 1974, some of the same elements remain as a mirror for professional staffs and Boards of Nursing to evaluate programs in nursing today. These elements are: organization and administration; faculty; physical facilities for instruction; students; curriculum; records and reports; evaluation, and cooperative relationships with agencies.

The administration and organization provide the visitor with information, such as philosophy and objectives. For instance, does the nursing program philosophy reflect the philosophy of the controlling institution? Are the objectives written in behavioral terms and do they describe the competencies of the graduated? These questions are valuable because they reveal the philosophical stance of the controlling agency and the general frame of reference of the nursing program in the controlling institution, as well as the staff and line relationships.

Financial support should be adequate, properly administered to provide instruction and other services which are called for in the institution, or program objectives.

Faculty qualifications differ from jurisdiction to jurisdiction; however, the Council of State Boards of Nursing adopted the following resolution in 1973:

The Resolution of Faculty Qualifications

WHEREAS, the responsibility for the preparation of future practitioners in nursing resides in nurse-faculty; and

WHEREAS, the faculty should serve as role models of lifelong learning for professional practice; and

WHEREAS, education for nursing reaches its ultimate aim—the improvement of nursing care—when advances in knowledge and practice are incorporated into the program of study in nursing; and

WHEREAS, the programs preparing practioners in nursing must assume the responsibility for many of the steps that prepare individuals to take their places on the career ladder in nursing; and

WHEREAS, both vertical and horizontal mobility are supported by society; therefore be it

RESOLVED, that the Council of State Boards of Nursing urges that by 1980 all nurse-faculty in all programs preparing persons for licensure as a nurse have as a minimum qualification an earned master's degree with graduate preparation in nursing and teaching.

We believe this resolution is worth working for and toward because ofthe need to improve educational programs and improve the quality of patient care. Faculty members should be prepared in their area of responsibility, and all students should have equal access to equally prepared faculty.

In regard to the physical facilities for program implementation, some questions raised are: Are they adequate to meet program objectives? Given the facilities, can the faculty implement changes without adversely affecting the educational programs? Can faculty members utilize facilities for adequate student learning?

In regard to students, does the admission criteria reflect program philosophy and objectives and faculty preparation? Once a student is admitted to a program, the institution has entered into a contractual agreement with that student and is obliged to fulfill this contract.

In regard to curriculum, the nursing faculty should select, organize, and assume responsibility for planning and implementing all experiences to achieve the educational objectives of the nursing program.

Complete records should be maintained to accomplish program objectives, such as records on faculty and students in the program. Minutes of meetings concerning program development are very valuable to assist the visitor to make a judgment on the total program operation. The annual report from the program is a valuable tool for information and follow-up.

The written systematic plan for total program evaluation should be based on the program's philosophy and objectives. The evaluation should reflect the program's strengths and weakness and should indicate where changes are needed.

These are only a few statements about the essential elements of a program in nursing and the value of these elements to the educational consultant and/or Boards of Nursing. Boards of Nursing must periodically review documents dealing with guidelines utilized in the accrediting (approving) process of agencies where programs are located. Such documents include the criteria of the National League for Nursing, Guides for the Evaluation of Institutions of Higher Eduction, and other accrediting guides, along with the Rules and Regulations of each jurisdiction and current trends in nursing and education. Faculties must be allowed and encouraged to develop programs in nursing based on sound educational principles. Evaluation of the performance of the program will vary with the general objectives of the institution/or specific objectives of the program.

**Adaptation: Cooperation—Creativity—Change**

Let's look at Illinois:

During 1973, increasing numbers of nurse-faculty demonstrated acceptance of the concept that education for career mobility in nursing appropriately belongs within the existing system of nursing education in the state.

Instead of concerning themselves exclusively with their own programs, or type of programs, nurse-faculty scrutinized the entire spectrum of nursing education in relation to health care needs, student aspirations, and the necessity to seek solutions cooperatively and on a broad geographic basis.

Not only did this change in focus result in expanding existing upward mobility efforts, it led to interprogram cooperation, restructuring curricula, and the search for new tools to measure competencies and validate previous experiences. The following examples indicate the scope of activities.

1. Enrichment Studies Program
   *School A*
   a. Well established, State approved, N.L.N. accredited
   b. Faculty: M.N.Ed., 8; B.S.N., 20; R.N.S.T., 3
   c. Students: 242
   d. State Boards Results: above state and national means
   e. Length of program: 27 months

The purpose of the Enrichment Studies Program conducted by the School A Hospital Nursing Program is to provide a tutorial program for educationally disadvantaged young women interested in enrolling in the School of Nursing.

This is the fourth year of the project. Although supportive services are needed for the young women, particularly in the beginning, there is evidence of growth in self confidence and self awareness as students continue in their nursing program, demonstrated by the fact that by the time they are seniors, they seek class leadership roles.

Another indication of the success of the Enrichment Studies Program is that one of the students received the highest score on State Board Examinations out of a class of 68 graduates.

2. Earning and Learning
   *School B*
   a. Well established, State approved, N.L.N. accredited
   b. Faculty: M.N., 3; B.S.N./B.S., 10; R.N., 2; A.A., 1
   c. Students: 139
   d. State Board Results: below state and national means
   e. Length of program: 5 terms

During 1970, the School B Hospital School of Nursing initiated an 18-month registered nursing curriculum designed specifically for licensed practical nurses. Since that time, 35 students were graduated. All passed the State Board registered nurse examinations. Currently there are 19 enrolled.

All students in this program continue to work. Some are responsible for the entire support of themselves and their families. There is a wide range in ages of students. At the present time, the oldest in the group is 58.

Graduates from this program have demonstrated leadership ability in a variety of areas. Several are head nurses in hospitals, another is the administrator of a Home Health Program. All are enthusiastic.

3. Open Curriculum System
   *School C*
   a. Well established, State approved, N.L.N. accredited
   b. Faculty: M.N., 4; M.A./M.S., 3; B.S.N., 3; B.S., 2
   c. Students: 208
   d. State Board Results: above state and national means
   e. Length of Program: 6 semesters

In May 1969, the School C Nursing Program initiated

a project of curriculum innovation. Initial goals include development of: (1) curriculum materials that would provide optional learning experiences for students; (2) a system of curriculum implementation that would facilitate use of optional learning experiences for meeting needs of differing learners; and (3) a learning resource center for support of the curriculum.

Since the beginning of the project, the school has completely revised the curriculum methodology, refined curriculum materials, and developed a variety of learning modules and submodules. The learning resource center includes 370 different programs.

The first class to have experienced the Open Curriculum System for the entire three year course of study graduated in June 1974.

4. Career Ladder L.P.N. to R.N.
   *School D*
   a. Ten years old; State approved, not N.L.N. accredited
   b. Faculty: M.N., 10; B.S.N., 5
   c. Students: 189
   d. State Board Results: above state and national means, with the exception of one area
   e. Length of program: 4 semesters
   *School E*
   a. Ten + years old; State approved, N.L.N. accredited
   b. Faculty: M.N., 5; B.S.N., 1
   c. Students: 94
   d. State Board Results: above state and national means with the exception of one area
   e. Length of program: 4 semesters

The Committee of Nurse Examiners and Department of Registration and Education approved nursing education in two community colleges, D and E, designed to offer the student a choice between two options:

1. The student terminates education at the end of the first year and qualifies for the practical nurse licensing examinations.
2. The student completes both first and second years of the program and qualifies for the registered nurse licensing examinations.

In addition to meeting criteria applied in the approval process to regular programs, the following also were required:

1. Competencies expected of the L.P.N. and the A.D.N. graduate are delineated, clearly stated, and indicate differences in the educational levels of the two programs.
2. There are identifiable components in the two years of education which are transferable from the one year to the other and which provide a base for further development during the final year.

5. Collegiate Common Market
   *School F*
   a. One + years old; State approved, not N.L.N. accredited
   b. Faculty: Ph.D., 1; M.S.N., 3; M.A., 1; B.S.N. 1; B.V. Tech. Ed. 1
   c. Students: 60
   d. State Board Results: 0
   e. Length of program: 2 semesters

At the present time there is no program preparing registered nurses in the 17 counties located in southern Illinois. It is highly improbable that any single agency could provide the faculty and the financial and clinical resources necessary for the program.

To fill this need for registered nurses, five educational institutions in the area formed a consortium, the Southern Illinois Collegiate Common Market, to serve as a vehicle whereby an associate degree nursing program could be established by utilizing the Open Curriculum Concept.

The program is designed to admit practical nurses graduated from the five institutions involved. Upon completion of course requirements, graduates will be eligible to write the registered nurse licensing examinations.

It is the purpose of the program to allow maximum credit to each student for previous related experiences and to make maximum use of individualized instruction and instructional technology that students may complete requirements at their own pace. Students expected to be admitted into the program will represent a broad spectrum of educational experiences as well as diversity in cultural backgrounds.

6. Interinstitutional Cooperation
   *School G*
   a. Ten + years old, State approved, N.L.N. accredited
   b. Faculty: M.N., 8; M.A., 1
   c. Students: 196
   d. State Board Results: above state and national means in two areas; below in three areas
   e. Length of program: 4 semesters

Community colleges G and H operate within an arrangement whereby the G nurse-faculty teach the nursing curriculum to a class of students from H College.

Required nonnursing courses for the associate degree program are taught by H general education faculty. Graduates from the program are granted the associate in nursing degree by H.

This plan for operation within the interinstitutional setting: (1) allows maximum use of clinical facilities and resources; (2) eliminates frustration associated with procurement of hard-to-obtain experimentially and academically prepared faculty; (3) provides students in the two colleges access to quality education; and (4) prepares registered nurses to meet needs of both communities.

7. Nursing Education in Two State Universities
   *Schools I and J*
   a. Four years old; State approved
   b. Faculties: Ph.D. I-2; Ph.D. J-3; M.S.N. J-2
   c. Student population: Diploma Graduates, A.D.N. graduates and graduate students
   d. Length of programs: Varied

An indication of diversity in nursing education programs in Illinois is demonstrated by offerings being planned by nurse faculty in two recently established universities. The two universities were given a mandate by the Illinois Legislature to be educationally experimental, innovative, and meet the educational needs of increasing numbers and varieties of students. Academic excellence and service to the community were regarded as being a serious responsibility.

It is hoped that nursing education will find a place of significance within the administrative structure and

philosophical framework of the two universities. Efforts toward that goal include implementing a flexible curriculum designed to effect qualitative and quantitative changes in practice through a varity of teaching modalities. Programs are to be future oriented, competency based and readily individualized.

The nursing program at State University I, along with two other open curriculum programs and the Collegiate Common Market, are part of the National League for Nursing Open Curriculum Project.

The Nursing Education Coordinators and the Committee of Nurse Examiners of the State Board have provided guidance, support, and encouragement to these schools all along the way. The objective has always been—Quality Education for the Student.

**Feasibility Studies Prior to Initial Accreditation**

The resources of the institution determine in large part the quality of the education and the learning experience provided. This includes the kind and quality of the instructional staff, the library and learning resources, the physical facilities, and the clinical laboratories. These resources should be readily accessible to the student.

I believe that in determining feasibility prior to initial accreditation, one must always return to the philosophy and objectives of the program, the faculty, students, and curriculum, because no single set of criteria can be judged for each nursing program. All feasibility studies should be judged in terms of the requirements of the program in nursing and the needs of the students.

Two of the most critical essential elements in today's society for programs, are faculty prepared at the master's level and clinical resources.

# Summary of Group Discussions

ISSUES: What functions should legal accreditation be expected to serve?
Are legal accreditation and licensure duplicative, complementary, or conflicting methods of identifying qualified nurses?
Should legal accreditation be discontinued in favor of voluntary accreditation and licensure?

There appeared to be consensus on the following: that one very important function of legal accreditation is the regulation of the numbers of nursing education programs to ensure quality education with adequate clinical experience; that legal accreditation and licensure are complementary because the former is a measuring device for the program while the latter is an individual one; that legal accreditation should *not* be discontinued because the standards used in voluntary accreditation are different for each of the three types of nursing education programs preparing for registered nurse practice but the differences in roles of the graduates have not been delineated.

ISSUES: What should be the role and responsibility of the State Board of Nursing in relation to planning for preservice education for nursing? Does the role differ when the planning is community-wide, statewide, and regional?

Among the roles and responsibilites of State Boards of Nursing suggested in relation to planning for preservice education were that Boards of Nursing: should be represented on planning committees; should be a resource on information relating to nursing and nursing education in their state—numbers of students, numbers of graduates, numbers of nurses entering and leaving the state, and the supply and demand for nurses; should take leadership in planning for the cooperative utilization of clinical and community facilities by nursing education programs; and should set faculty qualifications.

ISSUES: Who should be held accountable for education which purports to prepare persons for licensure?
What should be the role and responsibility of the State Board of Nursing in relation to innovations in programs preparing persons for nursing licensure?

There appeared to be consensus that both the faculty in a nursing education program and the State Board of Nursing should be held accountable and that the accountability was interdependent. The State Board of Nursing accountability related to its implementation of the sections of the nursing practice act pertaining to nursing programs and that the public should be informed if a particular program was not able to produce graduates capable of becoming licensed. Educators, on the other hand, must be accountable for preparing a practitioner who is ready to be a productive employee although it is recognized that "some" orientation is required for all beginning practitioners. Also, State Boards of Nursing should be held accountable for updating standards or criteria for accreditation/approval in keeping with changes in health care demands and delivery. However, educators have a responsibility for providing input into this process.

In relation to innovations in programs preparing persons for nursing licensure it was generally agreed that State Boards of Nursing should encourage and support new approaches but should also insist on systematic evaluation to determine the soundness of changes. It was also pointed out that the Council of State Boards of Nursing should continue to encourage some uniformity of standards among the states to facilitate mobility of licensees.

ISSUES: What should be the role and responsibility of the State Board of Nursing in relation to education for nursing vis-a-vis the professional association's role and responsibility?
What should be the role and responsibility of the State Board of Nursing beyond the preservice education?

It appeared to be a generally accepted fact that the professional association has the responsibility to establish, maintain, and improve standards of practice and the education essential for that practice. However, no clear consensus emerged regarding the two issues. One group did indicate that it believed that State Boards of Nursing had a responsibility to disseminate information regarding degree programs for nurses which are not in nursing.

**Suggestions/Recommendations Made By The Groups**

—State Board Rules and Regulations are based on "minimum" requirements. The terminology "minimum requirements" has objectionable connotations. Therefore, it is recommended that "legal requirements" be used in place of "minimum requirements."

—All State Boards of Nursing should give consideration to publishing reports of pass-fail results of candidates for licensure writing for the first time by school.

—As nurse practice acts are revised, it is recommended that State Boards of Nursing "approve" nursing education programs rather than "accredit" these programs.

—That the Council of State Boards of Nursing clearly define the entry levels to nursing practice and develop licensing examinations appropriate to the defined levels. (The nursing profession was also charged to spell out the differences between programs and their graduates.)

—That State Boards of Nursing address themselves to the study of articulation between programs so that students can transfer more easily from one program to another.

—There needs to be better rapport and communication between the various health licensing boards. It was recommended that these various boards work together to determine roles and functions.

—That State Boards of Nursing exert their legislative or regulatory power to control the initiation of new programs and continuation of education programs that do not meet standards.
—That State Boards of Nursing be actively encouraged by the profession through the American Nurses' Association at all levels to employ a sufficient number of qualified personnel to implement their regulatory functions.
—That a conference be planned with a focus on continuing competence of nurses to engage in practice.